

² Appellant filed a timely request for oral argument. By order dated February 19, 2016, the Board exercised its discretion and denied her request as her arguments could be adequately addressed in a decision based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 15-1363 (issued February 19, 2016).

FACTUAL HISTORY

On April 19, 1993 appellant, then a 37-year-old letter carrier, filed an occupational disease claim (Form CA-2) asserting that she developed right shoulder tendinitis and a rotator cuff injury as a result of performing repetitive duties at work. OWCP had initially denied appellant's claim but, on December 15, 2000, it accepted her claim for bilateral shoulder impingement syndrome and expanded her claim to include left shoulder and acromioclavicular joint degenerative joint disease. Appellant did not initially stop work, but returned to a light-duty position. She retired on January 27, 2014.

On December 19, 2000 appellant had filed a claim for a schedule award (Form CA-7). In a January 9, 2001 report, the OWCP medical adviser reviewed her medical records and opined that in accordance with the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*)³ appellant sustained 15 percent permanent impairment of the right arm. He diagnosed acromioclavicular right shoulder impingement syndrome.

In a decision dated January 18, 2001, OWCP granted appellant a schedule award for 15 percent permanent impairment of the right arm. The period of the award ran from August 15, 2000 to July 8, 2001.

On August 23, 2001 appellant requested an additional schedule award for a greater permanent impairment. In a May 1, 2002 report, the OWCP medical adviser reviewed the medical records and opined that in accordance with the fifth edition, A.M.A., *Guides*⁴ appellant had 20 percent impairment of the left upper extremity. He based his impairment rating on range of motion deficits and weakness in the axillary nerve. The medical adviser further noted that appellant sustained 22 percent impairment of the right upper extremity. He based his impairment rating on range of motion deficits and weakness in the axillary nerve.

In a decision dated May 28, 2002, OWCP granted appellant a schedule award for 22 percent permanent right arm impairment. The period of the award was from May 19 to October 18, 2002. OWCP noted that appellant had previously received a schedule award for 15 percent permanent right arm impairment and was therefore entitled to an award for an additional seven percent impairment.

In a January 14, 2003 decision, OWCP granted appellant a schedule award for 20 percent permanent impairment of the left arm. The award ran from October 19, 2002 to December 29, 2003.

Appellant came under the treatment of Dr. Thomas Branch, a Board-certified orthopedist, who, on May 31, 2006, performed an insertion of intra-articular pain pump, left shoulder arthroscopic distal clavicle resection, left shoulder arthroscopic superior labral tear from anterior to posterior repair, left shoulder arthroscopic subacromial decompression, and left shoulder

³ A.M.A., *Guides* (4th ed. 1993).

⁴ A.M.A., *Guides* (5th ed. 2001).

diagnostic arthroscopy. He diagnosed left shoulder arthritis, left shoulder biceps long head tenosynovitis, and left shoulder subacromial bursitis.

On August 1, 2006 appellant filed a claim for an additional schedule award.

In an October 20, 2006 report, an OWCP medical adviser reviewed the medical records provided and noted that appellant was undergoing injection treatment with Dr. Branch and had not reached maximum medical improvement. He noted a schedule award was premature until maximum medical improvement was reached.

On October 25, 2006 Dr. Branch administered injections into the left shoulder biceps and diagnosed left shoulder biceps long head tenosynovitis. On February 19, 2007 he performed left shoulder arthroscopic distal clavicle resection, left shoulder arthroscopic subacromial decompression, left shoulder diagnostic arthroscopy, left shoulder extensive debridement, and left shoulder biceps long head release. Dr. Branch diagnosed arthritis of the left shoulder and left shoulder biceps long head tenosynovitis.

On September 5, 2007 Dr. Branch performed a right shoulder arthroscopic distal clavicle resection, arthroscopic superior labral tear from anterior to posterior repair, arthroscopic subacromial decompression, and diagnostic arthroscopy. He diagnosed arthritis of the right shoulder, shoulder biceps long head tenosynovitis, shoulder labral detachment, and shoulder subacromial bursitis. In a report dated October 8, 2007, Dr. Branch diagnosed left degenerative joint disease, acromioclavicular joint. He opined that appellant had reached maximum medical improvement and in accordance with the fifth edition of the A.M.A., *Guides* had 15 percent permanent impairment of the left arm. A magnetic resonance imaging (MRI) scan of the right shoulder dated April 27, 2007 revealed acromioclavicular arthritis.

In a November 20, 2007 report, an OWCP medical adviser opined that appellant had 14 percent permanent impairment of her left arm. The medical adviser noted a typographical error in Dr. Branch's report when combining appellant's impairment rating. On January 14, 2008 Dr. Branch concurred with the medical adviser's finding.

In a decision dated March 31, 2008, OWCP denied appellant's claim for an additional schedule award, noting that the current 14 percent rating was less than the 20 percent previously awarded for the left arm.⁵

Appellant continued to be treated by Dr. Branch, who, on May 16, 2008 diagnosed arthrofibrosis and status post right shoulder surgery. Dr. Branch opined that appellant would require total right and left shoulder arthroplasties. On February 10, 2010 he diagnosed right and left shoulder arthritis and degenerative joint disease. On March 22, 2010 Dr. Branch performed a left shoulder hemicap hemiarthroplasty and diagnostic arthroscopy and diagnosed arthritis of the left shoulder and shoulder pain. He noted that the arthroscopy confirmed extensive grade IV articular surface changes of the humeral head and of the glenoid. In a March 14, 2013 report,

⁵ Appellant requested an oral hearing which was scheduled for August 26, 2008. She failed to appear for the scheduled hearing. In a September 15, 2008 decision, OWCP found that appellant abandoned her request for a hearing.

Dr. Branch diagnosed right bicipital tenosynovitis, disorder of the bursae and tendons in the shoulder region, pain in the joint shoulder region, and osteoarthritis. He recommended surgery. On June 12, 2013 Dr. Branch performed a right shoulder long head of the biceps release, diagnostic arthroscopy, extensive debridement, arthroscopic distal clavicle resection, and arthroscopic subacromial decompression. He diagnosed right shoulder dislocation, biceps long head rupture, biceps long head tenosynovitis, arthritis, subacromial bursitis, and shoulder arthrofibrosis. MRI scans of the right shoulder dated July 29, 2011 and June 6, 2012 revealed extensive artifacts from prior surgery compromising the study and, although the rotator cuff was obscured, there was no evidence of a large retracted rotator cuff tear.

On June 27, 2013 appellant again requested an increased schedule award. On July 1, 2013 OWCP requested appellant submit a medical report based on a recent examination which addressed whether she had reached maximum medical improvement, a diagnoses upon which impairment was based, a detailed description of any permanent impairment, and a final rating of permanent impairment as set forth in the A.M.A., *Guides*.⁶ No additional medical evidence was received.

In a decision dated August 12, 2013, OWCP denied appellant's claim for an additional schedule award. It noted that appellant had failed to submit medical evidence establishing that she sustained increased permanent impairment to a scheduled member.

On January 21, 2014 appellant requested reconsideration. She submitted a December 12, 2013 report from Dr. Branch. Dr. Branch noted positive biceps stress test for irritation and pain at the long head of the biceps, healed surgical incisions consistent with prior surgical procedures, ongoing weakness with pain about the cuff with functional testing bilaterally, strength testing bilaterally revealed weakness, range of motion was essentially symmetric with limitations in all planes, acromioclavicular joints were tender bilaterally, and shoulder crepitus was noted bilaterally. He noted that x-ray findings of the right shoulder demonstrated type 3 acromion with intact acromiohumeral interspace. Dr. Branch diagnosed right shoulder bursitis -- subacromial, degenerative joint disease of the acromioclavicular joint, shoulder pain, rupture of the tendon -- nontraumatic -- biceps long head, and painful prosthesis. He noted that in February 2007 appellant had undergone a left shoulder arthroscopic redo acromioplasty and biceps release with findings at that time of grade 3 to 4 degenerative humeral head changes and grade 2 to 3 changes about the glenoid. Dr. Branch noted that despite surgery appellant remained symptomatic. He also noted that on March 22, 2010 appellant had undergone a hemiarthroplasty about the left shoulder with humeral head hemicap placement. Dr. Branch noted that appellant remained symptomatic about the left shoulder and recently it was recommended that she have a total shoulder arthroplasty. He noted impairment for the right shoulder, pursuant to the A.M.A., *Guides*,⁷ Table 15-5, Shoulder Regional Grid, appellant was a class 1, grade E, rotator cuff injury, full-thickness tear, acromioclavicular joint status post distal clavicle resection, for 13 percent impairment of the right arm. With regard to the left shoulder, Table 15-5, Shoulder Regional Grid, appellant was a class 3, grade E, for a total shoulder arthroplasty complicated and unstable for 49 percent arm impairment. Dr. Branch noted that

⁶ A.M.A., *Guides* (6th ed. 2009).

⁷ A.M.A., *Guides* (6th ed. 2009).

pursuant to the Combined Values Chart appellant had 62 percent upper extremity impairment after combining 49 percent left upper extremity impairment with 26 percent right upper extremity.

In a February 5, 2014 report, the OWCP medical adviser reviewed the medical records and Dr. Branch's December 12, 2013 report. He noted that appellant had received schedule awards for 22 percent right arm impairment and 20 percent left arm impairment. For the right shoulder, appellant had two arthroscopic procedures with residual mild arthritis for 13 percent impairment of the right arm. The medical adviser indicated that appellant has already been awarded 22 percent schedule award for the same condition and was not eligible for another award. He noted that she underwent a left shoulder arthroplasty on March 22, 2010 with a complicated and unstable result. Under the A.M.A., *Guides*,⁸ Table 15-5, page 405, appellant was a class 3 and grade E severity for 46 percent left arm impairment. The medical adviser noted that appellant was previously paid 20 percent impairment for the left arm and was entitled to a schedule award for an additional 26 percent upper extremity impairment.

In a decision dated March 21, 2014, OWCP vacated the August 12, 2013 decision and advised that a separate decision would detail the schedule award.

In a decision dated March 27, 2014, OWCP granted appellant a scheduled award for an additional 26 percent permanent impairment for the left upper extremity.⁹ The period of the award ran from March 9, 2014 to September 27, 2015. OWCP noted that appellant had previously been awarded 20 percent permanent impairment of the left upper extremity and was entitled to a schedule award for an additional 26 percent, for a total award of 46 percent permanent impairment of the left upper extremity.

On February 3, 2015 appellant requested reconsideration. She submitted a report from Dr. Michael Sabatelle, a Board-certified orthopedist, dated March 30, 2015, who treated appellant in follow-up for bilateral shoulder pain. Dr. Sabatelle noted positive findings on examination and diagnosed bursitis subacromial, degenerative joint disease -- acromioclavicular joint, shoulder pain, rupture of the tendon, biceps long head, and painful prosthesis.

In a decision dated April 27, 2015, OWCP denied modification of the decision dated March 27, 2014, finding no additional impairment was warranted for either arm.

LEGAL PRECEDENT

The schedule award provision of FECA¹⁰ and its implementing federal regulations,¹¹ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However,

⁸ A.M.A., *Guides* (6th ed. 2009).

⁹ This superseded a March 26, 2014 schedule award decision which listed an incorrect award period.

¹⁰ 5 U.S.C. § 8107.

¹¹ 20 C.F.R. § 10.404.

FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.¹² For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.¹³ For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.¹⁴

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).¹⁵ Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).¹⁶ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁷ The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down the default value C, by the calculated net adjustment.¹⁸

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the OWCP medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the OWCP medical consultant providing rationale for the percentage of impairment specified.¹⁹

ANALYSIS

OWCP accepted appellant's claim for bilateral shoulder impingement syndrome and expanded her claim to include left shoulder degenerative joint disease and acromioclavicular joint. It authorized arthroscopic surgery which was performed on the left shoulder on May 31, 2006, February 19, 2007, and March 22, 2010, and on the right shoulder on May 27, 1993,

¹² *Id.* at § 10.404(a).

¹³ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

¹⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013) and Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

¹⁵ A.M.A., *Guides*, 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

¹⁶ *Id.* at 385-419.

¹⁷ *Id.* at 411.

¹⁸ *Id.* at 411-12.

¹⁹ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

September 5, 2007 and June 12, 2013.²⁰ On January 18, 2001 appellant was granted 15 percent permanent impairment of the right arm for acromioclavicular right shoulder impingement syndrome. She claimed an additional award and on May 28, 2002 she was granted an additional 7 percent permanent impairment of the right upper extremity for a total 22 percent impairment of the right arm due to her right shoulder condition. On January 14, 2003 OWCP awarded appellant 20 percent of the left upper extremity due to her left shoulder condition. Appellant claimed an additional award on March 27, 2014. OWCP granted her an additional 26 percent permanent impairment for the left upper extremity for a total award of 46 percent impairment due to her left shoulder condition.

In support of her request for an increased schedule award, appellant submitted a report from Dr. Branch dated December 12, 2013. Dr. Branch properly noted that pursuant to the A.M.A., *Guides*,²¹ for the right shoulder, Table 15-5, page 403, Shoulder Regional Grid, appellant was a class 1, grade E, rotator cuff injury, full-thickness tear, acromioclavicular joint status post distal clavicle resection, for 13 percent impairment of the upper extremity. With regard to the left shoulder, he noted that, pursuant to Table 15-5, Shoulder Regional Grid, appellant was a class 3, grade E, total shoulder arthroplasty, complicated and unstable, for 49 percent left upper extremity impairment. However, the shoulder regional grid²² contains no class 3 diagnoses with a grade E impairment of 49 percent. Rather, Table 15-5, Shoulder Regional Grid, class 3, grade E provides for 46 percent impairment rating. Further, Dr. Branch noted that using the Combined Values Chart to combine 49 percent left upper extremity impairment with 13 percent right upper extremity impairment for 62 percent upper extremity impairment. His determination of 62 percent impairment of the upper extremities is of limited probative value. Although he purports to use the Combined Values Chart under the A.M.A., *Guides*, his application is inconsistent with the instructions as set forth in the A.M.A., *Guides*, pages 22 and 23. The Combined Values Chart enables physicians to account for the effects of multiple impairments with a summary value for each extremity, but does not instruct the examiner to combine multiple extremities to determine upper extremity impairment.²³ As Dr. Branch's

²⁰ Appellant underwent a right subacromial decompression on May 27, 1993, left shoulder arthroscopic distal clavicle resection, left shoulder arthroscopic superior labral tear from anterior to posterior repair, left shoulder arthroscopic subacromial decompression and left shoulder diagnostic arthroscopy on May 31, 2006, a left shoulder arthroscopic distal clavicle resection, left shoulder arthroscopic subacromial decompression, shoulder diagnostic arthroscopy, left shoulder extensive debridement and left shoulder biceps long head release on February 19, 2007, a right shoulder arthroscopic distal clavicle resection, shoulder arthroscopic superior labral tear from anterior to posterior repair, right shoulder arthroscopic subacromial decompression on September 5, 2007, a left shoulder hemicap hemiarthroplasty on March 22, 2010 and a right shoulder long head of the biceps release, shoulder diagnostic arthroscopy, arthroscopy of the shoulder, extensive shoulder debridement, right shoulder arthroscopic distal clavicle resection, and shoulder arthroscopic subacromial decompression on June 12, 2013.

²¹ A.M.A., *Guides* (6th ed. 2009).

²² See A.M.A., *Guides* 401-05, Table 15-5.

²³ Cf. *Carl J. Cleary*, 57 ECAB 563 (2006) (each leg impairment is considered separately under FECA; there is no provision for bilateral leg impairment).

impairment rating is not properly based on the A.M.A., *Guides*, it is of limited probative value and OWCP properly referred the matter to its medical adviser.²⁴

In his February 5, 2014 report, the OWCP medical adviser reviewed the medical records and advised that while Dr. Branch's report of December 12, 2013 noted that appellant had 62 percent upper extremity impairment, this determination did not correlate with the A.M.A., *Guides*.²⁵ He noted that, for the right shoulder, appellant had two arthroscopic procedures with residual mild arthritis for 13 percent schedule award for the right upper extremity pursuant to Table 15-5, Shoulder Regional Grid. The medical adviser properly noted that appellant was already awarded 22 percent schedule award on May 28, 2002 for the same condition and was not eligible for another award. He noted that appellant underwent an arthroplasty of the left shoulder on March 22, 2010 with a complicated and unstable result. Pursuant to the A.M.A., *Guides*,²⁶ Table 15-5, page 405, appellant was a class 3 and grade E severity for 46 percent left arm impairment. The medical adviser noted appellant was previously paid 20 percent impairment for the left arm and had an additional 26 percent arm impairment.

Appellant submitted reports from Dr. Sabatelle dated March 30, 2015. However, Dr. Sabatelle did not address permanent impairment. The Board finds that there is no current medical evidence in accordance with the A.M.A., *Guides* which supports that appellant sustained more than 22 percent permanent impairment for the right upper extremity and 46 percent permanent impairment for the left upper extremity.

On appeal appellant asserts that Dr. Branch's report's outlined appellant's permanent impairment and substantiated her claim for a schedule award. However, as noted above, Dr. Branch's report failed to clearly explain how he arrived at 62 percent permanent upper extremity impairment pursuant to the A.M.A., *Guides*, and there is no provision for combining the impairment of both arms under FECA. Accordingly, his opinion is of limited probative value.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than 22 percent permanent impairment of the right upper extremity and 46 percent permanent impairment of the left upper extremity, for which she previously received schedule awards.

²⁴ See *Linda Beale*, 57 ECAB 429 (2006).

²⁵ A.M.A., *Guides* (6th ed. 2009).

²⁶ *Id.*

ORDER

IT IS HEREBY ORDERED that the April 27, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 24, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board